



August 21, 2017

Ms. Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert Humphrey Building -- Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attn: CMS-5522-P

RE: Proposed Rule regarding the Quality Payment Program, established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS 5522-P

Dear Administrator Verma:

On behalf of the over 4200 members of the Private Practice Section (PPS) of the 90,000 member American Physical Therapy Association (APTA), I write to offer comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule regarding the Quality Payment Program, established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), initiated in 2017, known as the transition year. The Program's main goals are to:

- Improve health outcomes.
- Spend wisely.
- Minimize burden of participation.
- Be fair and transparent.

Medicare Access and CHIP Reauthorization Act (MACRA) – On June 20, the Centers for Medicare and Medicaid Services (CMS) released the proposed CY 2018 Updates to the Quality Payment Program. This proposed rule implements the second year of the new Quality Payment Program (QPP) which includes two tracks: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models. The Quality Payment Program aims to:

- Support care improvement by focusing on better outcomes for patients, decreased clinician burden, and preservation of independent clinical practice;
- Promote adoption of APMs that align incentives for high-quality, low-cost care across healthcare stakeholders; and

- Advance existing delivery system reform efforts, including ensuring a smooth transition to a healthcare system that promotes high-value, efficient care through unification of CMS legacy programs.

In the proposed rule, CMS implements elements of MACRA that were not included in the first year of the program, including virtual groups, facility-based measurement, and improvement scoring. CMS also included proposals to continue implementing elements of MACRA that do not take effect in the first or second year of the Quality Payment Program (QPP), including policies related to the All-Payer Combination Option for identifying Qualifying APM Participants (QPs) and assessing eligible clinicians' participation in Other Payer Advanced APMs. Although many items are proposed to carry over from the 2017 program year other key flexibilities are implemented including a payment adjustment for the 2020 payment year ranging from -5% to + 5% (with a scaling factor) as required by law and a change in performance periods, i.e., Quality and Cost will remain on a 12-month calendar performance period while Advancing Care Information and (Clinical) Improvement Activities will require a 90 days minimum performance period.

PPS chooses to comment on these rule proposals despite the recognition that, by statute, physical therapists will not be eligible to participate, and therefore not affected by the MIPS/MACRA program policies until 2019 at the earliest. We have previously urged earlier participation because physical therapists are, for a period of two years at minimum, left without payment incentive options due to the demise of the PQRS program. Since this program will eventually be applied to private practice physical therapists we offer these comments on the following topics:

- A. Low-Volume Threshold**
- B. Virtual Groups**
- C. Topped Out Measures**
- D. Certified EHRs**
- E. Calculation of the Threshold Scores for QP Determinations**
- F. Submission of Information for Advanced APM Determinations**
- G. Advancing Care Information**
- H. Physician Focused Payment Models (PFPMs)**
- I. Small Practice Bonus**

A. Low-Volume Threshold

CMS describes this issue in the proposed rule:

The support of small, independent practices remains an important thematic objective for the implementation of the Quality Payment Program and is expected to be carried throughout future rulemaking. For MIPS performance periods occurring in 2017, many small practices are

excluded from new requirements due to the low-volume threshold, which was set at less than or equal to \$30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare Part B patients. We have heard feedback, however, from many small practices that challenges still exist in their ability to participate in the program. We are proposing additional flexibilities including: implementing the virtual groups provisions; increasing the low-volume threshold to less than or equal to \$90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B patients; adding a significant hardship exception from the advancing care information performance category for MIPS eligible clinicians in small practices; and providing bonus points that are added to the final scores of MIPS eligible clinicians who are in small practices. We believe that these additional flexibilities and reduction in barriers will further enhance the ability of small practices to participate successfully in the Quality Payment Program.

PPS COMMENT:

PPS applauds CMS for proposing to revise the low volume threshold previously established at \$30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare Part B patients based on feedback from the many small practices still experiencing challenges to participate in the program. Based on feedback from PPS membership, we support increasing the low-volume threshold to \$90,000 in Medicare Part B allowed charges or 200 Medicare Part B patients **on the condition that this is a per eligible clinician metric and not a group threshold.**

PPS also supports the addition of a significant hardship exception from the advancing care information performance category for MIPS eligible clinicians in small practices and providing bonus points that are added to the final scores of MIPS eligible clinicians who are in small practices. We believe that these additional flexibilities and reduction in barriers will further enhance the ability of small practices to participate successfully in the Quality Payment Program.

B. Virtual Groups

CMS proposes adding “Virtual Groups” as participation option for year 2, which would be composed of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” with at least 1 other such solo practitioner or group to participate in MIPS for a performance period of a year.

In order for solo practitioners to be eligible to join a Virtual Group, they would need to meet the definition of a MIPS eligible clinician and not be excluded from MIPS based on one of the 4 exclusions (new Medicare-enrolled eligible clinician; Qualifying APM Participant; Partial Qualifying APM Participant who chooses not to report on measures and activities under MIPS; and those who do not exceed the low-volume threshold). In order for groups of 10 or fewer eligible clinicians to be eligible to participate in MIPS as part of a Virtual Group, groups would need to exceed the low-volume threshold at the group level. A group that is part of a Virtual

Group may include eligible clinicians who do not meet the definition of a MIPS eligible clinician or may be excluded from MIPS based on one of the four exclusions.

Allow flexibility for solo practitioners and groups of 10 or fewer eligible clinicians to decide if they want to join or form a Virtual Group with other solo practitioners or groups of 10 or fewer eligible clinicians, regardless of location or specialties. If the group chooses to join or form a Virtual Group, all eligible clinicians under the TIN would be part of the Virtual Group.

CMS proposes various components that would need to be included in a formal written agreement between each member of the Virtual Group.

Virtual Groups that choose this participation option would need to make an election prior to the 2018 performance period (as outlined in the MACRA legislation).

If/when TIN/NPIs move to an APM, CMS proposes to exercise waiver authority so that CMS can use the APM score instead of the Virtual Group score.

Generally, policies that apply to groups would apply to Virtual Groups, except the following group-related policies:

Definition of non-patient facing MIPS eligible clinician.

- *Small practice status.*
- *Rural area and Health Professional Shortage Area designations.*

PPS COMMENT:

Because of its propensity to offer flexibility to small group and solo practitioners, PPS is in general agreement with the proposal to add Virtual Groups to the QPP.

C. Topped Out Measures

As defined in the CY 2017 Quality Payment Program final rule at (81 FR 77136), a measure may be considered topped out if measure performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made.

CMS proposes a 3-year timeline for identifying and proposing to remove topped out measures. After a measure has been identified as topped out for three consecutive years, we may propose to remove the measure through comment and rulemaking for the 4th year. Therefore, in the 4th year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting during the performance period. This proposal provides a path toward removing topped out measures over time, and will apply to the MIPS quality measures. QCDR measures that consistently are identified as topped out according to the same timeline as proposed below, would not be approved for use in year 4 during the QCDR self-nomination review process, and would not go through the comment and rulemaking process.

Starting with the 2018 MIPS performance year, CMS proposes to use a cap of 6 points for a select set of 6 topped out measures.

PPS COMMENT:

PPS supports the deletion of measures that prove to be less than meaningful because measure performance is so high and unvarying that distinctions and improvement in performance can no longer be made.

This is precisely why when this program is applied to physical therapists in private practice that CMS employ patient-centered measures that have robust psychometrics such as a patient's functional status. Such measures have sustainability due to the scientific evidence that underlies their development and implementation.

D. Certified EHRs

Physical therapists in private practice were not included in the electronic health record program from the outset and therefore have not been monetarily incentivized nor supported to invest in this vital communicative link. PPS notes that physical therapists in private practice were not included in the 1stCentury Cures Act provisions affecting how CEHRT impacts the Quality Payment Program's current transition year and future years. Moreover, not only are physical therapists in private practice disadvantaged in the MIPS by this exclusion but similarly disadvantaged with respect to participation in other Medicare programs such as the Medicare Shared Savings Program much of which is predicated on the necessity of having a highly functioning and interconnected electronic health record capabilities.

Consequently, in view of these demonstrable disadvantages, if and when EHR capability is included as a criterion for an Advancing Care Information bonus for private practice physical therapists, such bonus needs to be substantial.

E. Calculation of the Threshold Scores for QP Determinations

CMS proposes to increase the performance threshold from 3 points to 15 points and solicits comments on whether it should be higher or lower. Additional performance threshold remains at 70 points for exceptional performance.

PPS COMMENT:

PPS believes the increase of the performance threshold from 3 to 15 is excessively steep and urges moderation as more clinicians strive to adapt to this complex payment methodology. (We also caution that this is another example of how inclusion of therapists in the MIPS at some future date may not allow the gradual adaptation to this new method of payment as has been afforded those eligible professionals who have participated since the outset).

F. Submission of Information for Advanced APM Determinations

According to current regulation, *if a MIPS eligible clinician is on an APM Participation List on at least one of the APM participation assessment (Participation List “snapshot”) dates, the MIPS eligible clinician will be included in the APM Entity group for purposes of the APM scoring standard for the applicable performance year.*

PPS COMMENT:

Since physical therapists in private practice are not currently eligible for participation in the MIPS program, this scoring standard clearly exemplifies the flaws inherent in the gradual application of the program to eligible professionals (i.e., not including physical therapists in private practice from the outset). Because formation of these APMs is now incentivized and rewarded without physical therapist participation, they are provided a “jumpstart” on organization and operation. Consequently, it will be extremely challenging for physical therapists in private practice to enter such APMS at a later date.

G. Advancing Care Information

CMS proposes to

- *Allow MIPS eligible clinicians to use either the 2014 or 2015 Edition CEHRT in 2018; grant a bonus for using only 2015 Edition CEHRT.*
- *Add exclusions for the E-Prescribing and Health Information Exchange Measures.*
- *Add more Improvement Activities that show the use of CEHRT to the list eligible for an Advancing Care Information bonus.*
- *Allow a MIPS eligible clinician to not report on the Immunization Registry Reporting measure and potentially earn 5% each for reporting any of the Public Health and Clinical Data Registry Reporting measures as part of the performance score, up to 10%, and awarding an additional 5% bonus for reporting to an additional registry not reported under the performance score.*
- *Add a decertification exception for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017.*
- *Change the deadline for the exception application submission for 2017 and future years to be December 31 of the performance year.*
- *For small practices (15 or fewer clinicians), add a new category of hardship exceptions to reweight Advancing Care Information performance category to 0 and reallocate the Advancing Care Information performance category weight of 25% to the Quality performance category.*
- *Propose 2 policies retroactive to the transition year based on the 21st Century Cures Act, which was passed after publication of the Year 1 Final Rule:*
 - *Ambulatory surgical center (ASC)-based MIPS eligible clinicians will be automatically reweighted to 0.*

PPS COMMENT:

PPS wishes to take this opportunity to point out that none of the above criteria or provisions is applicable to nonphysician providers (suppliers) such as physical therapists in private practice. Therefore, when physical therapists are included in the MIPS program and subject to the provisions of “Advancing Care Information”, pertinent and meaningful criteria will need to be identified.

H. Physician Focused Payment Models (PFPMs)

In the CY 2017 Quality Payment Program final rule (81 FR 77555), CMS defined PFPM as an Alternative Payment Model in which: Medicare is a payer; eligible clinicians that are eligible professionals as defined in section 1848(k)(3)(B) of the Act are participants and play a core role in implementing the APM’s payment methodology; and the APM targets the quality and costs of services that eligible clinicians participating in the Alternative Payment Model provide, order, or can significantly influence.

Section 1868(c) of the Act established an innovative process for individuals and stakeholder entities (stakeholders) to propose physician- focused payment models (PFPMs) to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC, established under section 1868(c)(1)(A) of the Act, is a federal advisory committee comprised of 11 members that provides advice to the Secretary.

CMS solicits comments on broadening the definition of PFPM to include payment arrangements that involve Medicaid or the Children’s Health Insurance Program (CHIP) as a payer even if Medicare is not included as a payer. The Agency believes that this broadened definition might be more inclusive of potential PFPMs that could focus on areas not generally applicable to the Medicare population, and could engage more stakeholders in designing PFPMs.

PPS COMMENT:

PPS agrees with the Agency’s proposal to broaden the definition of PFPM to include payment arrangements with Medicare, Medicaid or CHIP. Such a definition might be more inclusive of potential PFPMs that could focus on areas not generally applicable to the Medicare population, and could engage more stakeholders in designing PFPMs.

Since the PTAC is an important avenue for the creation of innovative payment models and is charged with reviewing stakeholders’ proposed PFPMs, PPS urges CMS to initiate steps that would result in nonphysician representation on the PTAC. Specifically, we urge CMS to engage with the Comptroller General to ensure that a physical therapist with national recognition for expertise in physician-focused payment models and related delivery of care under the Medicare program is a participating member of PTAC as soon as is possible.

I. Small Practice Bonus

PPS COMMENT:

PPS generally agrees with the CMS proposal to adjust the final score of any eligible clinician or group who's in a small practice (defined in the regulations as 15 or fewer clinicians) by adding 5 points to the final score, as long as the eligible clinician or group submits data on at least 1 performance category in an applicable performance period. But given the disadvantages inherent in small practices, we urge the final score to be adjusted by a minimum of 10 points. Additionally, we strongly urge the small practice bonus be given to those who practice in rural areas as well.

Urging Caution

As stated above we are commenting on program policies that do not (yet) apply to physical therapists in private practice but may eventually affect us. These comments are offered in response to the specifics contained in the proposed rule and, unless otherwise specifically stated, should not be construed as an affirmation that program policies applied initially to physicians can be automatically extended to nonphysician providers. In other words, we are commenting now on the proposals at hand but reserve the right to offer more extensive and specific comments when and if the QPP policies are applied to physical therapists in private practice. Moreover, including physical therapists in private practice in the MIPS program after the program has been operational and applied to physicians for two or more years will need to allow therapists a similar opportunity to phase in to the program policies that have evolved to that time since the inception of the program.

Conclusion

PPS thanks CMS for the opportunity to provide these comments on the proposed rule and we are committed to meaningful and effective innovation in the Medicare program and pledges to continue its cooperation and collaboration with CMS. We look forward to more opportunities to partner with CMS in pursuit of meaningful and effective innovation in the Medicare program.

Sincerely,



Terrence Brown, PT, DPT
President, Private Practice Section of APTA